MFP Quality Workgroup

January 16, 2008

Present:

Teresa Larsen, ND P &A
Tess Frohlich-DHS-HCBS Waiver
Pam Tyler-Medcenter One Living Center
Deb Meuwissen- HCBS Case Manager Grand Forks County
Kristein Hasbargen- Richland County Director
Becky Roads- HCBS Case Manager, Williams County
Barb Murray- ND Association of Community Facilities
Vicci Pederson- DHS Developmental Disabilities
Sue Foerster- Developmental Center
Jake Reuter, MFP Grant Program Manager
Mary Teske HCBS Case Manager, Cass
Karen Tescher, Medical Services
Jake Reuter, MFP Grant Program Manager

Documents Reviewed: Minutes from December 17, 2007 meeting, Critical Incidents definitions and reporting form from Texas, Operational Protocol Section B. 8 Quality draft document

Initial reaction to prepared Operational Protocol document for section B.8 Quality
Jake acknowledged that Vicci and Tess were the authors of this document and that he appreciates their efforts very much.
HCBS Mary T. said the document looked fine. Pam indicated that she thought it was very thorough. Becky thought it looked good

Theresa mentioned we may want to include the P&A 24 hour on-call service. There is access to the P &A staff 24 hours. It could be a good part of assisting with the 24 hour back-up plan for the client.

Pam mentioned there needs to be some type of risk acceptance by the person and their family once they are discharged. They likely would not have a bed saved if they need to come back to the nursing facility.

Jake noted that also within the DD, their needs to be the risk assessment developed in the care plan as we do the discharge planning

Need a MFP consent signed to participate in the grant process. Both the nursing facility and the CIL's will be made aware that a person in the nursing facility wants to go home. Then they will meet and the individual will sign the consent. For nursing homes, it would be addressed in the discharge or individual plan.

The ombudsman program does not cover people in their homes, but there are crisis lines available through the Human Service Centers. We need to do more inquiry as to what they can handle. Barb mentioned her experience with the crisis line in the HSC was more psychiatric issues. They can be an avenue to access the Adult Protective Service and the police. **We will need to do more research through Nancy McKenzie as to what exactly the HSC's can assist with through their crisis line.**

Discussion was held that the proposed 24 hour call line could do triage and connect the individual with the appropriate service. There should be one number for them to call to avoid confusion. The plan for each person will need to be very individualized.
Even though P & A generally works with mentally ill and DD, they could funnel the call concerning HCBS individuals to the appropriate person, like Adult Services Protection.

ERS could be set up to list the first 3 or 4 choices to call for help. If none are available, it would need to be set up to call the ambulance.

WE need to be sure that we let the client know who will be notified if there are issues. This should be included in the risk acceptance. **This could be set up as conditions of participation.** This could be added to the discharge section.

On HCBS side, the plan will be developed through the nursing home and the CIL's. The individual plan will be developed before they move.

On the DD side, we look at appropriate services. When the person is accepted by the provider, all information that is sent by the Developmental Center will be included. For DD how do identify risk and do the assessment and develop a plan. The resident profile has been done and the risks for going into the community have been identified. Do we do it before they move from the Developmental Center? Yes.
If we have a list of all resources available by region so that the planning folks will have access to the information most needed it would improve the success of the backup plan development.

We will need to develop the process so that both systems can use it effectively. In the end there needs to be someone there for each person that will respond to them when needed.

The nursing service that Missouri is going to use stated they do get a lot of nonemergency phone calls and they triage and give them the assistance they need.

Fargo and Williston feedback: In Fargo, the call triage planning is what they are currently doing. If they are a competent adult, the system is in place and works. Pam would like to add dementia to the criteria for people being discharged home through the MFP grant. The MDS has very specific questions regarding the decision making area.

HCBS RISK MANAGEMENT:

Right now, we have designed an assessment tool to bring those issues to the surface so the HCBS manage, the CIL and NF discharge facility can look at those to develop the plan.
We could do something like the ICP, but there would be more information including what are the risks and the mitigation plan. Example: falls and the plan could be ERS. The risks would be moved forward to the care plan.

This tool will be developed.

The risks noted on the MDS will trigger discussion on the areas that need to be addressed. The assessment will be done by the CIL,s and the Nursing Facility staff. Once they transition into the community. The assessment will be on SAMS. Hopefully, the HCBS case manager can view the tool on SAMS and some of it can populate the HCBS assessment. They will involve the HCBS case managers as soon as possible.

Tess asked if we could get the list of MDS risks so we can include in the assessment tool. The MDS is very comprehensive and can be utilized to determine the risks when individual goes home. Jake noted that the HCBS case managers will be invited to be at the table at the discharge planning meeting prior to the individual going home. The first meeting will be very strategic to determine if needs can be met at home.

Once there is a release of information signed, the nursing facility can send information to be reviewed.

DD Risk Management
Note: Vicki wondered if when transitioning people out of the DC, can we do the interim case plan with the staff from the DC, the provider receiving the person and the case manager. This would deal with the risk assessment piece as to what is being done now and what can be implemented in the home setting. Sue thought this was a very realistic expectation because much of that is being done informally now. Even if they aren't coming out of the Developmental Center, the same process could be utilized. Will this be put into a special document? **Vicci, Barb, and Sue will look at current documentation and see if it includes all necessary risk management for MFP and develop a process. (They will also pull in a DD provider in the discussion) Consent documents etc. could be signed at the same time. Hopefully this will be a process that can be carried on after the MFP demonstration.**

Tess wondered if a DD individual is transitioning out of the nursing home, they would go to the DD case manager, especially if the services are coming out of the DD waiver.

Incident Management for HCBS and DD

Currently, there isn't any document in place. MFP asks us to define what we believe to be an incident. It would be expected that the QSP would notify the HCBS case manager of a critical incident. Then the CM would send it to Jake , the program manager.

When reviewing the Texas document related to critical incidents, Attachments A and B, Theresa asked to add seclusion as a restraint under # 5. Also to put an example for rendering a piece of equipment unusable (like an electric wheelchair turned off or brakes put on.
These would be put on e-forms and faxed in. It was suggested that we use these forms. We need to run them by legal and then use it.

Need to broaden the description under **Incident Details on the fomr**. Add risk management within immediate actions.
Are we going to use this for both populations? Vicci wants to adapt some of this to the DD process.
Short term plan for MFP: Use this form for now and then develop or change the form afterward. Deb suggested guiding the QSP's so they know exactly what they are expected to report. They should be given a copy of this when they are employed by the person that is enrolled in the MFP grant process. The Case managers would like to give it to the QSP. We could hand them a copy of the critical incidents form from Texas. Vicci thinks they need to add some of this to 006 portions for DD.

24 hour backup plan for HCBS and DD

- Initial discharge planning team looking at options for 24 hour backup which will be connected to their proactive risk prevention
- Contingency plans (could include family members)
- List of resources available in each region should be available at the discharge planning meeting.
- Must be specific to each individual
- 24 hour nurse line. The nurse must have the plan for the individuals that are part of the MFP grant. If all else fails this should be the resource used. The nurse must have a plan of who to call.
- On the DD side, they most always will have a provider (agency) that has a 24 hour response plan.

  Deb will send their resource that is given to seniors in the grand Forks area.
  The senior line also has many services available to give out as information.
  Vicci wants a list of things to consider when discharge planning.
  Tess noted that the risk mitigation list will really help trigger discussion for necessary services for the individual.
  Theresa noted that in some instances, **examples** would be helpful

  We will do some work on the documents following the discussion today and send out to the committee.
  Sue will send Jake a copy of the resident profile tool. She will send it electronically.

Appeal documents will be included. A reduction, termination, denial form will be given to the individual to describe the appeal process.
They must be mae aware of the appeal process.

We will not get together as a group again before submission, but will be kept abreast electronically.

Vicci, Theresa, Barb, and Jake will get together with an ICF/MR provider to further discuss the DD portion of these areas.